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Why Transgender Children Should Have the Right to Block their Own Puberty with Court Authorization

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WHY TRANSGENDER CHILDREN SHOULD HAVE THE RIGHT TO BLOCK THEIR OWN PUBERTY WITH COURT AUTHORIZATION

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ABSTRACT

Transgender children who wish to begin hormone suppression therapy are required to obtain their parents' consent. This Comment argues that children should be able to access such treatments with court authorization in situations where their parents do not consent to the treatment. Gender identity is protected under the fundamental right to liberty because it is part of the person's autonomy of self. Additionally, the United States Supreme Court's Fourteenth Amendment jurisprudence indicates that the right to make decisions pertaining to one's sexuality are within the ambit of the right to privacy. For this reason, children have a right to privacy that includes the ability to decide whether to take hormone suppressants. The State's interests in restricting this privacy right are not significant so as to render the parental consent requirement valid. Therefore, States must provide children with a judicial bypass procedure whereby they can access hormone suppression treatments without parental consent.

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*J.D. candidate, 2019, Florida International University (FIU) College of Law. This Comment is dedicated to all the children who don't feel comfortable in their own skin, and all the adults equipped with the tools to help. I wish to thank my family for their constant love and support. I would also like to thank Professor Cyra A. Choudhury for her guidance throughout the writing process. Special thanks to Adrian Karborani, Editor-in-Chief, and Annasofia Roig, Executive Managing Editor, for their patience, encouragement, and feedback throughout the writing and editing process. I am also indebted to Natalie Oyarzun, Amaia Sanz de Acedo, and Mary Corbin for their suggestions, inspiration, and moral support. Last, but certainly not least, thank you to the *FIU Law Review* Editorial Board and Staff for their extensive work on this Comment, and the entire issue.

I. INTRODUCTION

"No matter when you were born or where, puberty is the same. It's the same for your parents as it is for you—what's happening in your body dictates everything."[1] Puberty is a stage that is marked by physical, emotional, and psychological changes.[2] These changes are difficult for all children, but they are especially taxing on children who are transgender.[3] That is because the process serves as an indication that the transgender child "will permanently be a member of the sex opposite to the one they experience themselves to be."[4] Transgender children also have trouble connecting socially and romantically with their peers, leading to anxiety and depression.[5] However, the children can alleviate these problems by taking puberty blockers, which act to pause the puberty of their birth-assigned gender until their bodies are ready for more invasive treatments.[6]

Currently, there is neither a national nor international protocol to determine whether transgender children should be able to begin hormone therapy to suppress the development of sex characteristics of their birth-assigned gender.[7] In the absence of a protocol, two opposing views have emerged:

> [o]ne side argues that physical intervention should be delayed until the completion of puberty because teenagers are more likely than adults to change their minds about gender identity[], while t]he opposing view . . . argues for early endocrinologic intervention to prevent the severe depression that accompanies the onset of an unwanted

1 Francine Pascal, *Puberty Quotes*, BRAINY QUOTE, https://www.brainyquote.com/topics/puberty.

2 Bethany Gibson & Anita J. Catlin, *Care of the Child with the Desire to Change Gender – Part I*, 36 PEDIATRIC NURSING 53, 55 (2010).

3 *Id.*

4 Stephanie Brill and Jennifer Hastings, M.D., *Transgender Youth: Providing Medical Treatment for a Misunderstood Population*, NAT'L WOMEN'S HEALTH NETWORK (2009), https://www.nwhn.org/transgender-youth-providing-medical-treatment-for-a-misunderstood-population/.

5 Henriette A Delemarre-van de Waal & Peggy T Cohen-Kettenis, *Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects*, 155 EUR. J. OF ENDOCRINOLOGY S131, S131 (2006) [hereinafter Cohen-Kettenis].

6 Gibson & Catlin, *supra* note 2 at 55–56.

7 Norman Spack, *Transgenderism*, 12 LAHEY CLINIC MED. ETHICS J. 1, 2 (2005).

> puberty and to avoid the physically and psychologically painful procedures required to reverse puberty's physical manifestations.[8]

If a child wishes to begin hormone therapy, medical consent laws and Fourteenth Amendment jurisprudence require parental consent.[9] This requirement, however, proves problematic when the parents of the transgender child are not willing to consent to their child starting hormone therapy.

This Comment proposes that States should provide a judicial bypass procedure for transgender children who want to begin hormone suppression therapy without their parents' consent. Children have the right to make decisions concerning their gender identity because children enjoy the fundamental right to individual liberty, which encompasses the right to privacy and the right to individual autonomy. Although the United States Supreme Court's Fourteenth Amendment jurisprudence and common law dictate that parents must consent to their children's important medical decisions, the decision to transition is an exception. The State's interests in restricting children's privacy rights in that context are not significant to render the parental consent restriction valid. For this reason, States should provide minors with the option to obtain permission from a court to access the hormone treatments if they show either (1) that the decision was made in consultation with their physician, or (2) that the decision would be in their best interests. The decision to take puberty blockers will always be made with a physician consultation because such consultation is a requirement for beginning hormone therapy under both of the medical guidelines for transgender care. The decision will also always be in the child's best interests because of the reversibility of puberty blockers, and because of the negative and dangerous consequences of delaying transition.

Part II explains what being transgender is, what puberty blockers are, and also explains the current status of children's rights to make decisions. Part III proposes that children have a right to privacy that encompasses the right to make decisions concerning their gender identity. Part IV explains why the parental notice requirement inhibits children's privacy rights and is invalid because it does not serve a significant state interest. Part V introduces an adaptation of the *Bellotti v. Baird* test for a judicial bypass procedure that children may utilize to begin hormone therapy without parental consent.

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8 *Id.*

9 *See* Gibson & Catlin, *supra* note 2, at 55–56.

II. BACKGROUND

A. Transgender Background Information

"One's self-awareness as male or female evolves gradually during infant life and adulthood. This process of cognitive and affective learning happens in interaction with parents, peers, and environment."[10] However, normative psychological literature has yet to pinpoint when a person's sexual identity is crystallized.[11] Interestingly, almost all transgender adults felt like they were in the wrong body at the beginning of childhood.[12]

"[P]ersistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex" is one of the two criterions for Gender Identity Disorder (GID) under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).[13] Children exhibit this disturbance by engaging in any of the following:

> in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.[14]

The second criteria is "a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex."[15] To satisfy this criterion, the DSM-IV-TR indicates that children will demonstrate four or more of the following:

> 1) repeatedly stated desire to be, or insistence that he or she is, the other sex,
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> 2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing,

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10 Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132, 3135 (2009).

11 *Id.*

12 Spack, *supra* note 7, at 1.

13 AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) 576 (4th ed. 2000) [hereinafter DSM-IV-TR].

14 *Id.* at 581.

15 *Id.* at 576.

> 3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex,
>
> 4) intense desire to participate in the stereotypical games and pastimes of the other sex,
>
> 5) strong preference for playmates of the other sex.[16]

"Because GID may be accompanied with psychological or psychiatric problems, it is necessary that the clinician making the GID diagnosis be able 1) to make a distinction between GID and conditions that have similar features, 2) to diagnose accurately psychiatric conditions, and 3) to undertake appropriate treatment thereof."[17] The World Professional Association of Transgender Health Standards of Care (WPATH SOC) for the Health of Transsexual, Transgender, and Gender-Nonconforming People is the most recognized protocol for treating GID.[18] Formerly called the Harry Benjamin International Gender Dysphoria Association, the WPATH is a professional society of "mental health professionals, endocrinologists, internists[,] and surgeons."[19] The WPATH SOC outline the stages of treatment for individuals with GID, which begin with "'extensive exploration of psychological, family[,] and social issues' by a mental health professional," followed by reversible and then irreversible physical interventions.[20]

The WPATH SOC have identified two sets of criteria—eligibility and readiness—that both adults and minors must satisfy to begin physical interventions including hormone treatment and sex-reassignment surgery.[21] The criteria for beginning hormone therapy are different for adults and children, while the criteria for sex-reassignment surgery are the same.[22]

Hormone therapy begins with puberty blockers until the age of 16, when the individual can begin taking cross-sex hormones.[23] Puberty blockers, more formally referred to as gonadotropin-releasing hormone (GnRH) analogs, are

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16 *Id.* at 581.

17 Hembree et al., *supra* note 10, at 3136.

18 Lois Jeannine Bookhardt-Murray, *Care of the HIV-Infected Transgender Patient*, MEDSCAPE (Apr. 10, 2012), http://www.medscape.com/viewarticle/761434_11.

19 Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL INTERDISC. L.J. 179, 189 (2016).

20 Spack, *supra* note 7, at 2.

21 Hembree et al., *supra* note 10, at 3137–38.

22 *Id.*

23 Gibson & Catlin, *supra* note 2, at 57.

medications that suppress or inhibit puberty.[24] Puberty blockers pause the bodily changes that would normally occur during puberty by suppressing the body's production of testosterone or estrogen.[25] This in turn gives the child, the child's doctor, and the child's family time to explore and consider whether the child truly wishes to transition.[26] Hormone suppressing treatment also prevents the child from experiencing the emotional and psychological distress and discomfort of puberty in the child's birth-assigned gender.[27] Puberty blockers are recommended by both medical guidelines for GID treatment—the WPATH SOC and the Endocrine Society—because they are "fully reversible interventions."[28] If the child decides at any point that they no longer want to transition, the child can stop taking the puberty blockers and their body will begin puberty in their birth-assigned gender almost immediately.[29] The reversibility of puberty blockers reduces the risks of administering the medication to a child who was "wrongly diagnosed as gender dysphoric."[30]

B. Legal Background Information

The Fourteenth Amendment states: "[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law."[31] The United States Supreme Court has interpreted the fundamental right to liberty in the Fourteenth Amendment to include a right to privacy.[32] This right to privacy protects the individual's bodily integrity from interference by the State.[33] The fundamental right to liberty also encompasses "an autonomy of self that includes freedom of thought, belief, [and] expression."[34]

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24 Amy C. Tishelman, et al., *Serving Transgender Youth: Challenges Dilemmas, and Clinical Examples*, 46 AM. PSYCHOL ASS'N, 37, 40 (2015).

25 Priyanka Boghani, *When Transgender Kids Transition, Medical Risks Are Both Known and Unknown*, PBS (June 30, 2015), https://www.pbs.org/wgbh/frontline/article/when-transgender-kids-transition-medical-risks-are-both-known-and-unknown/.

26 *Id.*

27 *Id.*

28 Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J. TRANSGENDERISM 165, 166 (2007).

29 Hembree et al., *supra* note 10, at 3139.

30 Ikuta, *supra* note 19, at 217.

31 U.S. CONST. amend. XIV, § 1.

32 *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 915–16 (1992); Roe v. Wade, 410 U.S. 113, 152 (1973).

33 *Casey*, 505 U.S. at 849.

34 Lawrence v. Texas, 539 U.S. 558, 562 (2003).

The fundamental right to liberty has also been interpreted to include the right to parent.[35] Parents have a fundamental right "to make decisions concerning the care, custody, and control of their children" that is guaranteed to them by the Due Process Clause of the Fourteenth Amendment.[36] This right has been described as "essential,"[37] "basic in the structure of our society,"[38] and "established beyond debate as an enduring American tradition."[39] The Supreme Court first recognized this right in *Meyer v. Nebraska*, noting that the Due Process Clause includes the right of parents to "establish a home and bring up children" and "control the education of their own."[40] This is because the parents' "primary function and freedom include prepar[ing their children] for obligations[, a process which] the state can neither supply nor hinder."[41] Included within the right to parent is the parental consent requirement on a minor's right to make important decisions.[42]

However, the fundamental liberty right of parents to the custody, care, and nurture of their children is not absolute.[43] When a parent's decision jeopardizes a child's safety or physical or mental health, or has a potential for significant social burdens, the State is legally required to intervene as part of their role as *parens patriae*.[44] This is because the State has an interest in protecting the goals of a productive and self-perpetuating society as part of its role as guardian of the health and welfare of society at large.[45] More importantly, the State has "an independent interest in the well-being of its

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35 *See* Troxel v. Granville, 530 U.S. 57, 66 (2000).

36 *Id.*; *see also* Santosky v. Kramer, 455 U.S. 745, 753 (1982); Parham v. J.R., 442 U.S. 584, 602 (1979); Quilloin v. Walcott, 434 U.S. 246, 255 (1978); Stanley v. Illinois, 405 U.S. 645, 651 (1972); Wisconsin v. Yoder, 406 U.S. 205, 232–33 (1972); Prince v. Massachusetts, 321 U.S. 158, 166 (1944); Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925); Meyer v. Nebraska., 262 U.S. 390, 399, 401 (1923).

37 *Meyer*, 262 U.S. at 399.

38 Ginsberg v. New York, 390 U.S. 629, 639 (1968).

39 *Yoder*, 406 U.S. at 232.

40 *Meyer*, 262 U.S. at 399, 401.

41 *Prince*, 321 U.S. at 166.

42 Bellotti v. Baird, 443 U.S. 622, 640 (1979).

43 *See Prince*, 321 U.S. at 167 ("[T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare; and that . . . includes, to some extent, matters of conscience and religious conviction.").

44 *Yoder*, 406 U.S. at 233–34; Troxel v. Granville, 530 U.S. 57, 68–69 (2000) ("[S]o long as a parent adequately cares for his or her children (*i.e.*, is fit), there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children."); Parham v. J.R., 442 U.S. 584, 603 (1979) ("[A] state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized."); *id.* at 624 (Stewart, J., concurring) ("[T]he presumption that a parent is acting in the best interests of his child must be a rebuttable one, since certainly not all parents are actuated by the unselfish motive the law presumes.").

45 *See Prince*, 321 U.S. at 168.

youth."[46] As such, the State can infringe on parents' fundamental rights by regulating child labor and imposing requirements such as school attendance and vaccinations.[47] At the most extreme end of the spectrum, the State can also take custody of a minor child through court action if the child's parent fails to provide proper protection, thereby placing the child in danger.[48] The State has the power to invoke its *parens patriae* power at any point during the child's minority, but the power is strongest when the child is younger and more immature.[49] In this way, "[t]he *parens patriae* authority fades . . . as the minor gets older," and effectively disappears when the child reaches the age of majority.[50] The State's *parens patriae* power is also grounded in the justification that the State has a compelling interest in the preservation of human life.[51] For this reason, when a child's life is threatened by either parental action or neglect, the State has a legal duty to intervene.[52] These points demonstrate that the right to parent is limited.

The right to parent is also limited by the fact that children, as individual citizens, are also entitled to Constitutional protections.[53] The Supreme Court recognized this in *In re Gault* by stating, "whatever may be their precise impact, neither the Fourteenth Amendment nor the *Bill of Rights* is for adults alone."[54] The Court reiterated this concept in *Planned Parenthood of Central Missouri v. Danforth*, where it stated, "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority."[55]

The Supreme Court has recognized children's constitutional rights in a variety of different contexts. Such contexts include the application of the Fourteenth Amendment's applicability to juvenile delinquency proceedings;[56] and specifically, that minors "are entitled to adequate notice, the assistance of counsel, and the opportunity to confront their accusers" in those proceedings.[57] Criminal proceedings involving children apply the same

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46 Ginsberg v. New York, 390 U.S. 629, 640 (1968).

47 *Prince*, 321 U.S. at 166.

48 Susan D. Hawkins, Note, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment* Disputes, 64 FORDHAM L. REV. 2075, 2084 (1996).

49 *Id.*

50 *In re* E.G., 549 N.E.2d 322, 327 (Ill. 1989).

51 *See* Roe v. Wade, 410 U.S. 113 (1973); *In re E.G.*, 549 N.E.2d at 327.

52 *See In re E.G.*, 549 N.E.2d at 327.

53 *See* Bellotti v. Baird, 443 U.S. 622, 633 (1979).

54 *In re* Gault, 387 U.S. 1, 13 (1967).

55 Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976).

56 *See In re Gault*, 387 U.S. at 41.

57 *Bellotti*, 443 U.S. at 634.

standard of proof as adult proceedings—beyond a reasonable doubt[58]—and children are also entitled to assert the privilege against forced self-incrimination.[59] Additionally, the Court also held that the prohibition against double jeopardy also applies to children.[60] In regards to property interests, the Court in *Goss v. Lopez* held that children's property interests cannot be intruded upon without due process of law.[61] The Court also recognized that children have a constitutional right to free speech and expression in *Tinker*.[62]

Nevertheless, there are three reasons for why the constitutional rights of minors cannot be equated to those of adults: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing."[63] First, Supreme Court decisions involving children's claims to constitutional protections against deprivations of liberty reflect the Court's recognition of children's vulnerability.[64] In *Roper*, the Court held that the imposition of the death penalty on juveniles under the age of 18 violated the Eighth Amendment because of the three differences between juveniles and adults.[65] The Court noted that juveniles have "a lack of maturity and an underdeveloped sense of responsibility" that result in poor decision-making.[66] Additionally, minors are also more "susceptible to negative influences and . . . peer pressure."[67] Finally, the character of children is less developed than that of adults, and therefore children's personality traits are "more transitory, less fixed."[68] The Court's recognition of children's vulnerability is also reflected in the criminal adjudication context because minors' criminal adjudication occurs within a completely separate entity.[69]

Second, the Court has explicitly given States permission to limit children's freedom to make important decisions with potentially serious consequences without parental oversight.[70] The Court has stated that requiring a child to consult with his parent or guardian about important decisions is both in the child's best interests and ideal for ensuring the child

58 *See In re* Winship, 397 U.S. 358, 368 (1970).

59 *Bellotti*, 443 U.S. at 634.

60 *See* Breed v. Jones, 421 U.S. 519, 532–33 (1975).

61 *See* Goss v. Lopez, 419 U.S. 565, 574 (1975).

62 *See* Tinker v. Des Moines Indep. Cmty. Sch. Dist., 393 U.S. 503, 511 (1969).

63 *Bellotti*, 443 U.S. at 634.

64 *Id.*

65 *See* Roper v. Simmons, 543 U.S. 551, 568–70 (2005).

66 *Id.* at 569.

67 *Id.*

68 *Id.* at 570.

69 Bellotti v. Baird, 443 U.S. 622, 635 (1979).

70 *Id.*

makes the best decision.[71] However, this rationale is grounded on two crucial presumptions. First, "that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions."[72] The Court has stated that children do not "have the capacity to take care of themselves."[73] For this reason, parental consultation is ideal because children "lack the ability to make fully informed choices that take account of both immediate and long-range consequences."[74] Thus, the rationale behind the parental consent requirement is to protect the child from decisions that could be detrimental to the child.[75] This justification becomes even more evident when applied to decisions within the context of medical care. Parents are required to consent to their children's medical decisions because children are deemed immature, thus incapable of understanding the consequences and repercussions of important medical decisions.[76] The second and more important reason for the parental consent requirement is the assumption that parents will act in the best interests of their children, mainly because of the "natural bonds of affection" that exist between parent and child.[77]

Finally, parents' supervisory function in the raising of their children further justifies limiting children's freedoms.[78] The State requires parents to be involved in, and consent to, their children's important decisions because doing so protects children from their own immaturity and adverse government action.[79] Additionally, parents' right to care and control their children stems from parents' role as the parties who are primarily responsible for those obligations, both financially and ethically.[80] The State, as an

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71 *See id.* at 640.

72 Parham v. J.R., 442 U.S. 584, 602 (1979).

73 Schall v. Martin, 467 U.S. 253, 265 (1984).

74 *Bellotti*, 443 U.S. at 640.

75 *See id.* at 635.

76 *See id.* at 640; *see also* U.S. CONG., OTA-H-467, OFFICE OF TECH. ASSESSMENT: ADOLESCENT HEALTH VOLUME III: CROSS-CUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES, 123 (1991) ("One rationale [for requiring parental consent to healthcare for minors] is that minors lack the capacity to make their own health care decisions and need to be protected from their own improvident decision-making. The legal presumption that minors are incompetent rests at least in part on an assumption of courts and legislators that minors as a class lack the requisite capacity to make health care decisions for themselves.").

77 Parham v. J.R., 442 U.S. 584, 602 (1979); *see also* H.L. v. Matheson, 450 U.S. 398, 410 (1981) ("[P]arents have an important 'guiding role' to play in the upbringing of their children . . . which *presumptively* includes counseling them on important decisions." (emphasis added)).

78 *Bellotti*, 443 U.S. at 637.

79 *Id.*

80 *See id.* at 637–38.

"impersonal political institution[]," is not equipped to undertake the process of preparing children for their additional obligations.[81]

C. Individual Autonomy in the Sexual Rights Context: Planned Parenthood of Central Missouri v. Danforth *and* Carey v. Population Services International

Notwithstanding the differences between adults' and minors' constitutional rights, the Supreme Court has identified certain circumstances where the privacy and individual autonomy of children are protected under the Constitution to the same extent as adults. Notably, the Court's jurisprudence extending these privacy rights to minors is almost exclusively within the sexual rights context.[82] Specifically, the Supreme Court addressed minors' constitutionally protected right to have an abortion in *Planned Parenthood of Central Missouri v. Danforth* and the right to use nonprescription contraceptives in *Carey v. Population Services International*.[83] The Court based its reasoning in these two landmark cases on the fundamental right to liberty under the Fourteenth Amendment.[84]

In *Carey*, the Court acknowledged that minors have a fundamental liberty right to make individual choices about sexuality.[85] The Court described the right to decide whether to bear a child as "among the most private and sensitive."[86] Although the Court declined to "define 'the totality of the relationship of the juvenile and the state,'" it held that the right to privacy within the context of procreation extends to minors as well as adults.[87] For this reason, the Court's holding prohibits states from banning the sale of nonprescription contraceptives to minors.[88]

In the context of an abortion, the Court in *Danforth* rejected giving parents the power of an arbitrary veto over the abortion decision of a daughter who is mature enough to become pregnant.[89] In *Danforth*, the statute at issue conditioned an unmarried minor's ability to undergo an abortion during the first 12 weeks of pregnancy on the consent of a parent or person *in loco*

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81 *Id.* at 638.

82 *See generally Bellotti*, 443 U.S. at 633; Carey v. Population Servs. Int'l, 431 U.S. 678, 693 (1977); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976).

83 *Carey*, 431 U.S. at 694; *Danforth*, 428 U.S. at 74.

84 *See Bellotti*, 443 U.S. at 633; *Danforth*, 428 U.S. at 60; Roe v. Wade, 410 U.S. 113, 153–54 (1973).

85 *See Carey*, 431 U.S. at 692–94.

86 *Id.* at 685.

87 *Id.* at 692–93.

88 *Id.* at 681–82.

89 *Danforth*, 428 U.S. at 74.

parentis.[90] The Court held that "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent."[91]

In *Bellotti v. Baird*, the Supreme Court went one step further by requiring States to provide a pregnant minor with an alternative procedure through which to obtain an abortion without parental consent.[92] The Court acknowledged that encouraging a minor to consult with her parents when making the "grave" and "very important" decision of obtaining an abortion was ideal and constitutionally proper.[93] However, the Court stated that requiring this could become problematic in the context of an abortion.[94] The decision to have an abortion is extremely unique because it is very time-sensitive; the possibility of aborting "effectively expires in a matter of weeks from the onset of pregnancy."[95] Further, the consequences of the minor being denied the ability to have an abortion are more grave than for an adult.[96] If a minor is denied the ability to have the abortion, she is at a significantly greater disadvantage than an adult in the same position.[97] A minor is likely unable to financially support herself during the pregnancy and her child once it is born due to her lack of education, employment, and resources.[98] Thus, the Court held that every minor must be guaranteed the opportunity to go directly to a court to get authorization to make the abortion decision alone, without first having to consult or notify her parents.[99] The Court in *Bellotti* stated that a minor will be granted the authorization for an abortion if she shows either: "(1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests."[100]

Finally, in *Ohio v. Akron Center for Repdroductive Health*, the Court listed four criteria that a bypass provision must meet:

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90 *Id.*

91 *Id.*

92 *See* Bellotti v. Baird, 443 U.S. 622, 647–48 (1979).

93 *Id.* at 640–41.

94 *Id.* at 642 ("The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a State to act with particular sensitivity when it legislates to foster parental involvement in this matter.").

95 *Id.*

96 *Id.*

97 *Id.*

98 *Id.*

99 *Id.* at 647–48.

100 *Id.* at 643–44.

> [(1)] allow the minor to show that she possesses the maturity and information to make her abortion decision, in consultation with her physician, without regard to her parents' wishes[; (2)] allow the minor to show that, even if she cannot make the abortion decision by herself, 'the desired abortion would be in her best interests'[; (3)] insure the minor's anonymity[; and (4)] courts must conduct a bypass procedure with expedition to allow the minor an effective opportunity to obtain the abortion.[101]

The Court's holding dictates that certain important medical decisions require a judicial bypass to the parental consent requirement because parental consultation is not always in the child's best interests. With this legal framework in mind, I will now discuss why hormone suppression therapy as a minor is one such decision where allowing the parents to have an arbitrary veto can have potentially grave consequences.

III. CHILDREN HAVE A CONSTITUTIONAL RIGHT TO PRIVACY

In *Lawrence v. Texas*, the Supreme Court stated that the right to individual autonomy is included within the fundamental right to liberty guaranteed to all citizens by the Fourteenth Amendment's Due Process Clause.[102] The fundamental right to liberty also encompasses "an autonomy of self that includes freedom of thought, belief, [and] expression."[103]

Gender identity is defined as one's "actual or perceived sex, and includes a person's identity, appearance, or behavior, whether or not that identity, appearance, or behavior is different from that traditionally associated with the person's sex at birth."[104] Because gender identity is part of the person's autonomy of self, it follows that gender identity is protected under the fundamental right to liberty.[105]

The Supreme Court's opinions in *Planned Parenthood of Central Missouri v. Danforth* and *Carey v. Population Services International* further

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101 497 U.S. 502, 511–13 (1990) (citing *Bellotti*, 443 U.S. at 643–44).

102 539 U.S. at 574; *see also* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.").

103 *Lawrence*, 539 U.S. at 562.

104 Alexander John Goodrum, *Gender Identity 101: A Transgender Primer*, S. ARIZ. GENDER ALLIANCE (1998) at 53, 53.

105 *See Casey*, 505 U.S. at 851 ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."); *see also Lawrence*, 539 U.S. at 574.

support that the right to make decisions pertaining to one's sexuality are within the ambit of the fundamental right to privacy protected by the Fourteenth Amendment. In those decisions, the Supreme Court specifically extended the right to privacy, which flows from the fundamental right to liberty, to a minor's ability to obtain an abortion and nonprescription contraceptives without parental consent.[106]

As discussed above, the United States Supreme Court has acknowledged that minors are entitled to the protections of the Constitution, including the right to individual autonomy and the right to privacy.[107] Accordingly, it follows that minors are entitled to the Fourteenth Amendment's fundamental right to individual liberty, which includes the right to identify with the gender of their choice.

IV. CONSTITUTIONAL SCRUTINY TEST

Having established that minors have individual privacy rights, it follows that the parental consent requirement represents a state restriction on that right. There is a heightened standard of scrutiny for when the State acts to limit or restrain a minor's right to privacy. "State restrictions inhibiting privacy rights of minors are valid *only* if they serve 'any *significant* state interest . . . that is not present in the case of an adult.'"[108] Notably, this standard of review is significantly less rigorous than that of strict scrutiny, which is required when evaluating adults' privacy rights under the Fourteenth Amendment's Due Process Clause.[109] This is due in part to the fact that the State's control over children's activities is broader than that of adults.[110] Additionally, the level of scrutiny is also reduced because the right of privacy involved is that of making decisions independently, and the Court's jurisprudence has considered children to have a reduced capacity in making important decisions.[111]

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106 *See* Bellotti v. Baird, 443 U.S. 622, 643–44 (1979); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976).

107 *See Danforth*, 428 U.S. at 74; *In re* Gault, 387 U.S. 1, 13 (1967).

108 Carey v. Population Servs. Int'l, 431 U.S. 678, 693 (1977) (emphasis added) (quoting *Danforth*, 428 U.S. at 75).

109 *See Carey*, 431 U.S. at 693 n.15.

110 *Danforth*, 428 U.S. at 74 ("The Court indeed, however, long has recognized that the State has somewhat broader authority to regulate the activities of children than adults."); Ginsberg v. New York, 390 U.S. 629, 640 (1968) ("It is, therefore, altogether fitting and proper for a state to include in a statute designed to regulate the sale of pornography to children special standards, broader than those embodied in legislation aimed at controlling dissemination of such material to adults."); Prince v. Massachusetts, 321 U.S. 158, 170 (1944) ("[T]he power of the state to control the conduct of children reaches beyond the scope of its authority over adults . . . .").

111 *Carey*, 431 U.S. at 693 n.15; *see also Bellotti*, 443 U.S. at 635.

The Court applied this test in *Planned Parenthood v. Danforth*, where a state statute required the consent of a parent or person *in loco parentis* as a condition for an unmarried minor to undergo an abortion during the first 12 weeks of pregnancy.[112] The first interest the Court considered was that of "safeguarding . . . the family unit and of parental authority."[113] The Court found it difficult to believe that granting a parent the power to veto a decision to terminate the minor's pregnancy made by the minor patient and her doctor would "strengthen the family unit."[114] Further, granting such a veto power to a nonconsenting parent likely would not improve that parent's authority or control when the minor's pregnancy has likely already severed the family bond.[115] "Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant."[116] Thus, the Court held that the statute, which imposed a special consent requirement that was exercisable by someone other than the pregnant minor or her physician, violated *Roe v. Wade* because its justifications were insufficient.[117]

Likewise, imposing the parental consent requirement on a minor's decision to begin hormone suppression treatments is not sufficiently justified so as to pass constitutional scrutiny. When applied to the context of a transgender adolescent seeking to take puberty blockers, the parental consent requirement is not valid because it does not serve any significant state interest.

It is important to note that unlike the requirement in *Danforth*, the requirement at issue here is not specifically mandated pursuant to a specific statute. Rather, the requirement is an established common law rule which stems from the general constitutional requirement that parents must consent to decisions concerning their children's medical care.[118] Nevertheless, the parental consent requirement serves as a restriction that inhibits the minor's privacy right to access hormone treatment without parental consent.

The Court in *Danforth* noted that the State interests served by the parental consent requirement for the abortion decision—protecting parents' role in their children's decision-making and protecting children from making

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112 *Danforth*, 428 U.S. at 74.

113 *Id.* at 75.

114 *Id.*

115 *Id.*

116 *Id.*

117 *Id.*

118 Parham v. J.R., 442 U.S. 584, 603 (1979); *see also* Bellotti v. Baird, 443 U.S. 622, 640 (1979) ("[P]arental notice and consent are qualifications that typically may be imposed by the State on a minor's right to make important decisions."); Dalizza D. Marques-Lopez, Comment, *Not So Gray Anymore: A Mature Minor's Capacity to Consent to Medical Treatment*, UNIV. HOUS. PERSP. ON HEALTH L. (Oct. 2006), https://www.law.uh.edu/healthlaw/perspectives/2006/%28DM%29MatureMinor.pdf.

detrimental choices—did not justify the intrusion on the child's right to privacy.[119] Similarly, the State interests served by the parental consent requirement also do not justify denying a minor the ability to take puberty blockers without parental consent. The State's interest in protecting the child from making a decision with long-term consequences is addressed by the medical guidelines for transition. "Psychological or psychiatric involvement, for a minimum period of six months before [puberty blocker] treatment and continuing until surgery" is one of the requirements for hormone therapy for minors.[120] This extensive supervision by a mental health professional will protect the child from making a choice that could be detrimental to them. Additionally, the Court has also listed the long-term consequences of forcing a minor to have a baby as a reason for allowing the minor to obtain an abortion.[121] Likewise, forcing a minor with GID to undergo puberty and wait until they reach the age of majority to begin transition will also have negative long-term consequences.[122] Transgender children who are forced to undergo puberty in their birth-assigned gender are at a higher risk of suicide, will likely suffer depression and anxiety, and may turn to the black market to access the hormone treatments.[123]

Furthermore, a transgender minor's decision to begin transition is significantly more "private and sensitive" than the decision to procreate or abort a child. The decision to procreate or use nonprescription contraceptives is simple: do I want a child or not? Likewise, the decision of whether to abort a child, albeit more personal, is still a purely medical decision. Neither of these decisions call for an inquiry into the person's identity and sense of self as in the decision whether to transition. As Professor Chai Feldblum states, "the liberty interest recognized by the [C]ourt in *Lawrence*—the right 'to define one's own concept of existence'—is an interest that speaks directly to . . . the efforts of transgender people to define their gender identity and expression"[124] The decision of whether to transition is one that is as complex as it is intimate. Therefore, the benefits of parental consent are not as weighty as with other purely medical decisions since those decisions do not speak directly to a person's sense of self. The United States Supreme Court has stated that "the choice to get married, to have a child, and to have sexual intimacy with a person of the same gender or opposite gender" are all included in the liberty interest of the Due Process Clause of the Fourteenth

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119 *Danforth*, 428 U.S. at 74–75.

120 Cohen-Kettenis, *supra* note 5, at S133.

121 Bellotti v. Baird, 443 U.S. 622, 642 (1979).

122 Spack, *supra* note 7 at 2; Gibson & Catlin, *supra* note 2, at 54–56.

123 Spack, *supra* note 7 at 2; Gibson & Catlin, *supra* note 2, at 54–56.

124 *See* Chai R. Feldblum, *The Right to Define One's Own Concept of Existence: What Lawrence Can Mean for Intersex and Transgender People*, 7 GEO. J. GENDER & L. 115, 116 (2006).

Amendment.[125] The choice to transition to one's preferred gender clearly falls within this legal framework. Thus, the State does not have the power to dictate when and whether an individual, minor, or adult makes this decision.

It follows that a transgender minor should be able to take hormone blockers before puberty without parental consent because the decision is inherently an individual one that should be made independently. Thus, minors should not be denied the ability to begin puberty suppressing treatments when their parents refuse to consent. As noted above, the Court has held that "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the *physician* and his patient."[126] Imposing a conditional parental consent requirement on a minor's choice to begin taking puberty blockers would constitute a "blanket veto" that the Supreme Court has ruled is unconstitutional.[127] However, states could avoid imposing this arbitrary veto by creating a judicial bypass procedure whereby children seeking to take puberty blockers could do so without their parents' consent.

V. APPLYING THE *BELLOTTI V. BAIRD* JUDICIAL BYPASS PROCEDURE

The Court in *Bellotti v. Baird* stated that a minor will be granted the authorization for an abortion if she shows either: "(1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests."[128] This test could be modified and applied to an adolescent seeking authorization from a court to take puberty blockers without having to provide parental notice or consent.

A. Prong (1): Consultation with a Physician

Being that a minor is as young as nine years old when they are eligible to begin taking puberty blockers, the portion of the *Bellotti v. Baird* test that requires the minor to show they are mature enough to make their decision independently is not applicable. Puberty blockers have to be administered as

125 *Id.* at 126.

126 Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976) (emphasis added).

127 *See Bellotti*, 443 U.S. at 643; *cf. Danforth*, 428 U.S. at 74 (holding that "the State may not impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy.").

128 *See Bellotti*, 443 U.S. at 643–44.

soon as puberty changes have begun.[129] Puberty changes begin with the development of secondary sex characteristics.[130] In boys, the first physical change is the growth of the testes and an increase in testosterone.[131] In girls, the first sign of puberty is the increase in fat and breast tissue, which usually follows the start of breast development.[132] The first menstrual period usually happens about two years later.[133] Puberty blockers work by "freezing" the minor's development to prevent the arrival of distinct secondary sex characteristics.[134] The Endocrine Society refers to the Tanner Scale to determine when adolescents should begin treatment with puberty blockers.[135] The Tanner Scale separates physical development into stages that begin from childhood, and continue through adolescence into adulthood.[136] Each Tanner stage is based on external primary and secondary sex characteristics.[137] The Endocrine Society guidelines indicate that puberty blockers can begin during Stage Two to Stage Four, but they are most effective if they begin during Stage Two.[138] Girls generally begin Stage Two at about eleven years old, at which point their breasts have not begun developing.[139] Boys enter Stage Two at thirteen years old, and at that point their testes have not yet enlarged.[140]

Furthermore, while it may be difficult to show that a minor is well-enough informed to make this decision independently of their parents' wishes, the *Bellotti* test accounts for this deficiency by involving a physician. A minor that wants to begin taking puberty suppressing hormones is not making this decision on their own. Rather, in order to begin *any* physical intervention, a transgender person must have first been assessed by medical professionals both physically and psychologically.[141] The two main medical guidelines that have been developed to guide the treatment of transgender

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129 *Id.* at 643.

130 Neil J. Salkind, *Puberty, in* ENCYCLOPEDIA OF HUMAN DEVELOPMENT 1051 (Neil J. Salkind ed., 2005).

131 Hembree et al., *supra* note 10, at 3140.

132 *Id.*

133 *Id.*

134 Jesse Green, *S/He: Parents of Transgender Children are Faced with a Difficult Decision, and It's One They Have to Make Sooner Than They Ever Imagined*, NEW YORKER MAG. (May 27, 2012), http://nymag.com/news/features/transgender-children-2012-6/.

135 *Id.*

136 *Id.*

137 Justin Corfield, *Tanner Stages, in* ENCYCLOPEDIA OF GLOBAL HEALTH 1643–44 (Yawei Zhang ed., 2008); *see also* Hembree et al., *supra* note 10, at 3141, 3143.

138 Green, *supra* note 134.

139 *Id.*

140 *Id.*

141 *See* Ikuta, *supra* note 19, at 189; *see also id.* at 216 ("The SOC and Endocrine Society guidelines stipulate that puberty blockers be administered only after the child has been diagnosed with gender dysphoria or GID and after psychiatric or mental health evaluations.").

people both require extensive assessment by medical professionals prior to commencing treatment.[142] The WPATH SOC advocates that physicians conduct an "extensive exploration of psychological, family, and social issues" before initiating any sort of physical intervention.[143] Additionally, the WPATH SOC specifically includes special guidelines that account for children's mental and psychological developmental differences.[144] Under the WPATH SOC, minors seeking to begin treatment must "demonstrat[e] a long-lasting and intense pattern of gender non-conformity, [prove that their] gender dysphoria emerged or worsened with the onset of puberty," and show that they do not have other medical or psychological problems that would interfere with the treatments sought.[145] Similarly, the Endocrine Society notes that diagnostic procedures for adolescents typically involve a "complete psychodiagnostic assessment and, preferably, a child psychiatric evaluation."[146] The Endocrine Society is "a professional international organization devoted to research on hormones and clinical practice of endocrinology" that issues the other medical guideline for the treatment of people with GID.[147]

Thus, a minor who wishes to begin treatment with puberty blockers would only be able to petition the court for authorization after acquiring their physician's authorization. The Supreme Court has noted that "[w]hat is best for a child is an individual medical decision that must be left to the judgment of physicians in each case."[148] And therefore, in the case where the physician, after the extensive assessments required under the transgender medical guidelines, approves of the child's hormone blocker treatment, the minor should be allowed to begin the treatment with the court's approval. The extensive psychological assessments required under the transgender medical guidelines are specifically designed to reduce the chances of rash or impulsive decisions by the minor to begin treatment. "The usual justification for a parental consent or notification provision is that it supports the authority of a parent who is presumed to act in the minor's best interests and thereby assures that the minor's decision . . . is knowing, intelligent, and deliberate."[149] The fact that a physician would be required to assess and approve of the child's puberty blocker treatment would ensure that the child's

142 *See* Ikuta, *supra* note 19, at 189.

143 Coleman et al., *supra* note 28, at 176.

144 *See* Amanda Kennedy, *Because We Say So: The Unfortunate Denial of Rights to Transgender Minors Regarding Transition*, 19 HASTINGS WOMEN'S L.J. 281, 283 (2008).

145 Coleman, *supra* note 143, at 177.

146 Hembree et al., *supra* note 10, at 3136–37.

147 Ikuta, *supra* note 19, at 190.

148 *See* Parham v. J.R., 442 U.S. 584, 608 (1979).

149 Hodgson v. Minnesota, 497 U.S. 417, 450 (1990).

decision was truly in their best interests, and was knowing, intelligent, and deliberate.

B. Prong (2): It Is in the Child's Best Interests

Further, even if the minor is not able to meet the first criterion of the bypass procedure set out in *Bellotti v. Baird*, the minor undoubtedly meets the second criterion. The second criterion states that even if the child is not able to make the decision independently, she may still get authorization if the desired procedure would be in her best interests.[150] The decision to allow the child to begin the physical intervention would be in the child's best interests because denying minors the ability to take puberty blockers prior to undergoing puberty has both medical and financial repercussions. "As compared with starting sex reassignment long after the first phases of puberty, a benefit of pubertal suppression is a relief of gender dysphoria and a better psychological and physical outcome."[151]

Also, allowing a transgender child to begin taking puberty blockers is in their best interests because hormone blockers are reversible. Puberty blockers are a group of medications, prescribed by endocrinologists, that suppress or inhibit puberty.[152] Puberty-suppressing hormones "freeze" the child's development before the child begins to develop secondary sex characteristics.[153] They do this by suppressing the body's development of either testosterone or estrogen.[154] The child continues taking the puberty blockers until they reach the age of sixteen.[155] At that point, the child will then begin taking cross-hormones, which will cause them to undergo adolescence in their desired gender instead of the gender they were assigned at birth.[156] Therefore, if the individual decides to undergo surgery later on, there are less physical attributes of the wrong gender to correct or get rid of.[157]

Allowing a minor to begin taking puberty blockers without parental consent is in their best interests because the effects of hormone treatments

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150 *See* Bellotti v. Baird, 442 U.S. 622, 643–44 (1979).

151 Hembree et al., *supra* note 10, at 3140.

152 Tishelman, *supra* note 24, at 39–40.

153 *See* Ikuta, *supra* note 19, at 214.

154 Susan Scutti, *Transgender Youth: Are Puberty-Blocking Drugs an Appropriate Medical Intervention?*, MED. DAILY (Jun. 24, 2013, 2:17 PM), http://www.medicaldaily.com/transgender-youth-are-puberty-blocking-drugs-appropriate-medical-intervention-247082.

155 Hembree et al., *supra* note 10, at 3132.

156 *Id.* at 3132–33; Green, *supra* note 134.

157 Green, *supra* note 134.

are reversible and have no known negative consequences.[158] The Endocrine Society declares that "[p]rolonged pubertal suppression using GnRH analogues [also referred to as puberty blockers] is reversible and should not prevent resumption of pubertal development upon cessation of treatment."[159] The reversibility and low risk associated with puberty blockers also severely undermines the Supreme Court's justification for the parental consent requirement because the decision does not necessarily have long-term, serious repercussions.[160] The reversibility of puberty blockers also offers the benefit that the likelihood of administering hormone treatment to a child who turns out not to have gender dysphoria is minimal.[161] If the individual taking the puberty blockers does not become a transgender adult or does not want to transition, the individual simply needs to stop taking the puberty-suppressing drugs to re-start their puberty development.[162] Their development in their assigned sex will resume almost immediately after the minor stops the hormone suppressing treatment.[163] Ultimately, puberty blockers pose a minimal risk of "post-treatment regret" as compared to other procedures that permanently alter the body, such as cross-hormones or surgical intervention.[164]

Puberty blockers are also in the child's best interests because they buy the child time while the child determines if they truly want to transition. The treatment gives adolescents "time to reflect over their gender identity, without becoming trapped in a body that [feels] alien" and unnatural to them and may well not reflect their ultimate gender identity.[165] Delaying puberty also has the benefit of ensuring "greater diagnostic precision" because both the child and the doctor can "further explore their gender identity and wish for sex reassignment."[166] It also allows time for the child's parents and other family members to "get counseling and support as needed, notify and educate school personnel, and explore the full range of treatment options."[167] In this way, puberty blockers also alleviate the emotional distress and discomfort of

158 *See* Ikuta, *supra* note 19, at 194.

159 Hembree et al., *supra* note 10, at 3139.

160 *See* Roper v. Simmons, 543 U.S. 551, 569–70 (2005).

161 Kathryn Hickey, *Minors' Rights in Medical Decision Making*, 9 JONA'S HEALTHCARE L., ETHICS, & REG. 100, 104 (2007).

162 Hembree et al., *supra* note 10, at 3141.

163 *Id.*

164 Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Surgery*, 31 N.Y.U. REV. L. & SOC. CHANGE 361, 388 (2007).

165 Simona Giordano, *Lives in Chiaroscuro. Should we Suspend the Puberty of Children with Gender Identity Disorder?*, 34 J. MED. ETHICS 580, 580 (2008).

166 Gibson & Catlin, *supra* note 2, at 56.

167 *Id.*

being forced to undergo puberty in the birth-assigned gender.[168] Therefore, the consequences of denying minors the ability to begin puberty suppression treatments indicate that allowing children to undergo the treatments without parental consent is in their best interests.

Further, allowing children to utilize a judicial bypass procedure to access puberty blockers is in their best interests because of the negative and dangerous effects of delaying transition. The rationale behind the parental consent requirement is to protect the child from decisions that could be detrimental to them. However, *denying*, rather than allowing, a minor the ability to begin transitioning to the sex they identify with would be detrimental to them.[169] Gender dysphoria is classified as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[170]

Minors with gender dysphoria suffer because of the disconnect between their assigned gender and their expressed gender. As a child with gender dysphoria starts to grow up and becomes more self-aware, they "evaluate themselves on the basis of gender compatibility . . . and suffer discomfort, even despair, when they come up wanting."[171] As the child continues to grow up, this stress increases since "[t]hey have to cope with adverse consequences of living with a self-concept that is never socially acknowledge or reinforced."[172] The Endocrine Society guidelines state that "an adolescent with GID often considers the pubertal physical changes to be unbearable."[173] The guidelines indicate that forcing a minor with GID to undergo puberty—rather than begin taking puberty blockers—puts the minor under significant stress.[174] This stress, in turn, puts the minor "at high risk of violence, suicide, and substance abuse."[175] Suicide rates are two to three times higher among LGBT youth.[176] On the other hand, hormone treatment has actually been proven to alleviate depression and reduce the risk of suicide in minors with

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168 *Id.*

169 Ikuta, s*upra* note 19, at 211.

170 Mark Moran, *New Gender Dysphoria Criteria Replace GID*, PSYCHIATRIC NEWS, Apr. 5, 2013, at 9, https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2013.4a19.

171 Susan K. Egan & David G. Perry, *Gender Identity: A Multidimensional Analysis with Implications for Psychosocial Adjustment*, 37 DEV. PSYCHOL. 451, 453 (2001).

172 Peggy T. Cohen-Kettenis & Stephanie H.M van Goozen, *Sex Reassignment of Adolescent Transsexuals: A Follow-up Study*, 36 J. AM ACAD. CHILD ADOLESCENT PSYCHIATRY 263, 263 (1997).

173 Hembree et al., *supra* note 10, at 3139.

174 *See* Hembree et al., *supra* note 10; *see also* Giordano, *supra* note 165, at 581.

175 Ikuta, s*upra* note 19, at 212.

176 *Fact Sheet: Bullying and LGBT Youth*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/sites/
default/files/BACK%20TO%20SCHOOL%202014%20-%20Bullying%20and%20LGBT%20Youth.pdf (last visited Oct. 12, 2018).

gender dysphoria.[177] This is because "[t]he opportunity to take hormones can facilitate gender self-determination, validating gender youths' assertion of their gender identities and providing them with a greater degree of control over the gender co-constructed through their daily interactions."[178]

Allowing the minor to undergo puberty (in lieu of taking puberty suppressing hormones) also leads the minor to experience "anxiety, depression, and confusion."[179] The minor will also avoid romantic relationships and friendships with classmates, making their adolescence out of sync with their peers.[180] Even in situations where the minor does not avoid his peers, gender nonconforming children are often times bullied and harassed at school.[181] In fact, almost two-thirds of LGBT youth interviewed by GLSEN for its survey on harassment in schools stated they had been harassed at school that year.[182] Over forty percent of the children reported feeling unsafe at school because of their gender expression when they were asked how their gender expression affected their schooling.[183] Over twenty-five percent of the children surveyed reported they had heard their teachers or other faculty members make negative comments about a student's gender expression.[184] Forty-six percent of the children reported they had been verbally harassed by other students because of their gender expression, while twenty-six percent of students reported being physically harassed.[185] As a result of this harassment, gender nonconforming youth oftentimes stop attending school altogether; they are five times more likely to miss school because of fear for their personal safety than heterosexual students.[186] Over

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177 Mauren Carroll, *Comment: Transgender Youth, Adolescent Decisionmaking, and* Roper v. Simmons, 56 UCLA L. REV. 725, 734–35 (2009).

178 *Id.* at 735.

179 Ikuta, s*upra* note 19, at 213.

180 Peggy T. Cohen-Kettenis & Louis J.G. Gooren, *The Influence of Hormone Treatment on Psychological Functioning of Transsexuals*, 5 J. PSYCHOL. & HUMAN SEXUALITY 55, 56–57 (1992).

181 Joseph G. Kosciw & Elizabeth M. Diaz, *The 2005 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*, GAY, LESBIAN & STRAIGHT EDUC. NETWORK 21–27 (2006) https://www.glsen.org/sites/default/files/2005%20National%20School%20Climate%20Survey%20Full%20Report.pdf.

182 *Id.* at 23.

183 *Id.* at 21.

184 *Id.* at 16.

185 *Id.* at 26.

186 Robert Garofalo et. al., *The Association Between Health Risk Behaviors and Sexual Orientation among a School-based Sample of Adolescents*, 101 PEDIATRICS 895, 900 (1998).

twenty-five percent of LGBT youth drop out of school, which is more than triple the national average.[187]

Denying minors with gender dysphoria the opportunity to begin treatments also results in physical health risks. Children who are denied access to puberty suppressing hormones from their doctors sometimes take matters into their own hands. These youth will find ways to initiate transition on their own without the benefits and safety precautions of medical advice or supervision. The child will sometimes "'obtain medication [from] the illegal market' and expose themselves to life-threatening conditions through unsupervised use of these drugs."[188] A study conducted by the San Francisco Department of Public Health found that about thirty percent of male-to-female individuals surveyed who had taken hormones in the last six months had acquired them illegally.[189] The risks involved in using illegally obtained hormones are twofold. The child might face criminal charges, or become subject to criminal justice proceedings.[190] Worse still, the individual might contract HIV from using a dirty needle.[191] The individual might also inject the improper dose, which could result in long-lasting side effects in the best-case scenario, or death in the worst-case scenario.[192]

Further, "[d]elaying sex reassignment until adulthood makes transitioning more difficult, less convincing, more expensive, and more invasive."[193] And even with surgery and cross-hormones, these obstacles are very difficult to completely rectify.[194] The development of secondary sex characteristics—such as an adam's apple, hips, or breasts—is permanent without invasive surgical intervention.[195] This invasive surgical intervention undoubtedly poses a much greater health risk than allowing the child to take puberty suppressing hormones. For an individual born as a male, puberty begins with the development of a deeper voice and a beard, which can be

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187 *Fact Sheet: Bullying and LGBT Youth*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/sites/default/files/BACK%20TO%20SCHOOL%202014%20-%20Bullying%20and%20LGBT%20Youth.pdf (last visited Oct. 12, 2018).

188 Ikuta, s*upra* note 19, at 213 (quoting Giordano, *supra* note 165, at 581).

189 Kristen Clements-Nolle et al., *HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgendered Persons: Implications for Public Health Intervention*, 91 AM. J. PUB. HEALTH 915, 917 tbl.1 (2001).

190 Giordano, *supra* note 165, at 581.

191 T. Nemoto et. al., *HIV Risk Behaviors Among Male-to-Female Transgenders in Comparison with Homosexual or Bisexual Males and Heterosexual Females*, 11 AIDS CARE 297, 311 (1999).

192 *Id.*

193 David Alan Perkiss, *Boy or Girl: Who Gets to Decide? Gender-Nonconforming Children in Child Custody Cases*, 25 HASTINGS WOMEN'S L.J. 57, 63 (2014).

194 Ikuta, s*upra* note 19, at 213.

195 *Id.*

very difficult to change when the individual wants to transition to a female.[196] Likewise, an individual born as a female will begin to develop hips and breasts, which will also be hard to eliminate later.[197] "In fact, the primary cause of health issues for postoperative transsexual people are factors that make it difficult for them to pass as their [own] gender or remind them of their transsexualism."[198]

These factors indicate that, in situations where the minor cannot show she is mature enough to make the decision on her own, the court should authorize her ability to begin hormone treatment because it is in her best interests. Moreover, this would also directly align with the State's role as *parens patriae*. As noted above, when a parent's decision jeopardizes the mental or physical health of the child or the child's safety, the State is legally required to intervene.[199] This is because when the child's parents make decisions that jeopardize the health and safety of the child, they are effectively rebutting the presumption that parents will act in the best interests of their child.[200] In fact, the Supreme Court's jurisprudence reflects the fact that "the Court abandons its deferential stance when treatment implicates sensitive interests and cannot be postponed without causing harm to the child."[201] Such is the case with both seeking an abortion, as seen in *Planned Parenthood of Missouri v. Danforth*, and in gaining access to nonprescription contraceptives, as seen in *Carey v. Population Services International*. And the situation involving access to puberty blockers is no different. Therefore, when a parent refuses to consent to a child's desire to begin puberty-suppressing hormone treatment, which is in the child's best interests and protects the child's health and safety, the State must step in as *parens patriae*. One way in which the State can intervene and ensure that the child's interests are protected is by creating a judicial bypass procedure by which the court can authorize the child's access to the puberty blockers treatment. Furthermore, the issues involved in gender identity implicate private concerns, and thus delaying the child's access to the treatment could result in harm to the child's health and safety. This supports the circumvention of the traditional parental consent requirement for medical care.

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196 Henk Asscherman & Louis J.G. Gooren, *Hormone Treatment in Transsexuals*, 5 J. PSYCHOL. & HUMAN SEXUALITY 39, 40 (1992).

197 *Id.* at 39–40.

198 Ikuta, s*upra* note 19, at 213.

199 Wisconsin v. Yoder, 406 U.S. 205, 233–34 (1972).

200 Parham v. J.R., 442 U.S. 584, 624 (1979).

201 Emily A. Bishop, Note, *A Child's Expertise: Establishing Statutory Protection for Interested Children who Reject Their Gender of Assignment*, 82 N.Y.U. L. REV. 531, 559 (2007).

VI. CONCLUSION

Having to go through puberty in the gender that you do not associate with can be both frustrating and extremely uncomfortable. Transgender youth that are forced to go through puberty in their birth-assigned gender experience stress, anxiety, and depression in the best-case scenario, and commit suicide in the worst. When these children are denied access to puberty suppressing medications by their parents, the State should exercise its *parens patriae* power and authorize the treatment via a judicial bypass. Doing so is in the best interests of transgender children because puberty blockers' effects are completely reversible; if the child decides they no longer want to transition, they can stop the treatments and undergo puberty. Puberty blockers also buy time for the child and the child's doctors to determine whether the child truly wants to transition. Additionally, puberty blockers give the child's family members time to come to terms with the child's plan to transition. Finally, hormone suppression treatment is in the child's best interests because delaying transition has dangerous repercussions, including depression, suicide, or contracting HIV from administering black market hormone treatments.